DOCUMENT RESUME

ED 347 753 EC 301 369

TITLE	Medicaid Coverage of Health-Related Services for Children Receiving Special Education: An Examination of Federal Policies.
INSTITUTION	Fox Health Policy Consultants, Washington, DC.; Lewin and Associates, Inc., Washington, D.C.
SPONS AGENCY	Health Care Financing Administration (DHHS), Washington, DC.; Office of Special Education and Rehabilitative Services (ED), Washington, DC.; Office of the Assistant Secretary for Planning and Evaluation (DHHS), Washington, D.C.
PUB DATE	Nov 91
NOTE	23p.
PUB TYPE	Guides - Non-Classroom Use (055)
EDRS PRICE	MF01/PC01 Plus Postage.
DESCRIPTORS	Administrative Policy; Ancillary School Services; *Disabilities; Elementary Secondary Education; *Federal Aid; *Financial Policy; *Financial Support; Guidelines; Health Services; Individualized Education Programs; Preschool Education; *Pupil Personnel Services
IDENTIFIERS	*Individuals with Disabilities Education Act Part B; *Medicaid

ABSTRACT

This booklet, organized in a question and answer format, is designed to help state and local education officials, Medicaid officials, and others understand the federal policies governing conditions under which the Medicaid program can pay for the related services required by the individualized education program of a child with disabilities. An overview presents basic information on Part B of the Individuals with Disabilities Education Act (IDEA) and the Medicaid program. The questions are grouped as follows: IDEA policy regarding Medicaid billing; Medicaid policy regarding payment for health-related services; Medicaid coverage of health-related services; Medicaid eligibility and enrollment; provider participation in the Medicaid program; Medicaid reimbursement rates and claims submission; Medicaid state plans; and certification of state's share of Medicaid program costs. (DB)

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MEDICAID COVERAGE OF HEALTH-RELATED SERVICES FOR CHILDREN RECEIVING SPECIAL EDUCATION:

AN EXAMINATION OF FEDERAL POLICIES

EC 301369

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Medicaid Coverage of Health-Related Services for Children Receiving Special Education: An Examination of Federal Policies

Prepared For:

Office of the Assistant Secretary for Planning and Evaluation

U.S. Department of Health and Human Services

In Cooperation With:

Health Care Financing Administration

U.S. Department of Health and Human Services

and

Office of Special Education and Rehabilitative Services

U.S. Department of Education

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November 1991

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OVERVIEW

Part B of the Individuals with Disabilities Education Act (IDEA) authorizes Federal funding to states in order to ensure that children with one or more of thirteen specified disabilities receive a free appropriate public education. The law was established by Public Law 94-142 and was formerly called the Education of the Handicapped Act. Under the law, school districts must prepare an Individualized Education Program (IEP) for each child eligible for services under Part B, specifying all special education and "related services" needed by the child. A state Medicaid program can pay for those "related services" that are specified in the Federal Medicaid statute and determined to be medically necessary by the state Medicaid agency.

Within Federal and state Medicaid program requirements regarding allowable services and providers, school districts can bill the Medicaid program for these health-related services when provided to children enrolled in Medicaid. This is important because of the additional financing it offers to educational agencies. The Part B program requires states to provide all special education and related services to eligible students at no cost to parents, but many states find this difficult because they are constrained by limited education budgets.

This booklet is designed to help state and local education officials, Medicaid officials, and other interested parties understand the conditions under which the Medicaid program can pay for the related services required by an IEP. It also describes the extent to which state Medicaid eligibility, coverage, and reimbursement policies are governed by Federal law.[1]

The booklet is organized in a "Question and Answer" format. We strongly recommend that the reader review the complete range of questions and answers given the complexity of the issues presented. The remainder of this overview provides background information on the two relevant programs: the Assistance to States Program established under Part B of IDEA, and the Federal/state Medicaid program established under Title XIX of the Social Security Act. A list of the questions addressed by the booklet is provided in Exhibit 1.

A. THE PART B PROGRAM

The Federal entitlement program that governs services to children with one or more of thirteen specified physical or mental disabilities who by reason thereof require special education and related services is authorized under Part B of the Individuals with Disabilities Education Act.[2] The Part B program is administered by the Office of Special Education and Rehabilitative

[1] Several states have been subject to court decisions in this area. However, since courts have limited jurisdiction and since Medicaid and education policies differ across states, these decisions may not apply generally to all states. Consequently, we do not discuss these legal cases in the booklet.

[2] This booklet does not address Part H of IDEA, which provides for services to infants and toddlers with disabilities. As with Part B services, Medicaid can be billed for health-related services under Part H. We did not cover Part H Medicaid funding in this booklet, however, because it is subject to fewer complex requirements than Part B and has already been covered in such documents as "The Role of Medicaid and EPSDT in Financing Early Intervention and Preschool Special Education Services" prepared by Fox Health Policy Consultants with funding from the Bureau of Maternal and Child Health, Department of Health and Human Services (DHHS).

Exhibit 1
QUESTIONS

A. IDEA POLICY REGARDING MEDICAID BILLING

1. Does Federal Part B policy allow Medicaid billing for health-related services covered under a state's Medicaid program?
2. Are there any Federal special education policies that limit the circumstances under which the Medicaid program can be billed for health-related services?

B. MEDICAID POLICY REGARDING PAYMENT FOR HEALTH-RELATED SERVICES

1. What are the Federal Medicaid program requirements regarding reimbursement for health-related services?
2. Are there any Federal Medicaid policies that limit the circumstances under which the Medicaid program can be billed for health-related services?
3. What state Medicaid policies must be in place in order for schools to bill Medicaid for medically necessary health-related services?
4. If a Medicaid recipient also has private insurance, must the private plan be billed for health-related services?
5. If providers bill a state Medicaid program for services to Medicaid recipients, must they also bill non-Medicaid children's parents or third-party payers for health-related services?

C. MEDICAID COVERAGE OF HEALTH-RELATED SERVICES

1. Which health-related services are Federally allowable Medicaid services?
2. What is meant by the Federal Medicaid requirement that a service be medically necessary?
3. What is the Medicaid EPSDT program for children?
4. What is the significance of the new Federal EPSDT mandate to furnish all medically necessary diagnostic and treatment services?
5. Are health-related services included under the new EPSDT mandate?
6. What is necessary for schools to bill for expanded EPSDT services?

D. MEDICAID ELIGIBILITY AND ENROLLMENT

1. Which children are eligible for Medicaid?
2. How do eligible children become enrolled in Medicaid?
3. Is it a violation of Medicaid confidentiality requirements for local education agencies to require parents to provide information on the Medicaid enrollment status of children receiving health-related services?
4. Can Medicaid enrollment information be furnished to education agencies by the state Medicaid program?

Exhibit 1
QUESTIONS
(continued)

E. PROVIDER PARTICIPATION IN THE MEDICAID PROGRAM

1. What Federal requirements must be met to become a provider of Medicaid services?
2. Is state licensure ever Federally required for providers of particular Medicaid services?
3. May schools qualify as Medicaid providers and bill for health-related services?
4. What are examples of provider qualifications that have been Federally approved for health-related services?
5. What is the financial liability of Medicaid providers in cases where reimbursement is subsequently disallowed by HCFA?

F. MEDICAID REIMBURSEMENT RATES AND CLAIMS SUBMISSION

1. What are the Federal requirements governing Medicaid payments to providers?
2. What methods can states use to determine Medicaid payment rates for covered services?
3. How are Medicaid-covered services billed?
4. Who can bill for reimbursable services?
5. What kinds of records must be maintained by Medicaid providers?
6. Must providers show evidence of billing other liable third parties prior to billing Medicaid?

G. MEDICAID STATE PLANS

1. What are the Federal requirements for state Medicaid plans?
2. How are state Medicaid plans revised?
3. Who can submit Medicaid plan amendments?

H. CERTIFICATION OF THE STATE'S SHARE OF MEDICAID PROGRAM COSTS

1. What kinds of funds may be used to provide a state's share of Medicaid program costs?
2. What is required for state and local education agencies to certify their contribution?

Services within the U.S. Department of Education. Grants are distributed to states, which then disburse most of the funds to local education agencies (e.g., school districts) to support their special education activities.

The grants under Part B are intended to assist states in assuring that children with specified disabilities receive a free appropriate public education as specified in the Act. A "free appropriate public education" is defined to include special education and related services at no cost to the parents.

- "Special education" is defined as "specially designed instruction, at no cost to the parent, to meet the unique needs of a child with a disability." It can include classroom instruction, instruction in physical education, home instruction, and instruction in hospitals and institutions to ensure that children with disabilities receive a free appropriate public education.
- "Related services" are defined as "transportation, and such developmental, corrective and other supportive services as are required to assist a child with a disability to benefit from special education." These include several health-related services that must be available, including speech pathology, audiology, psychological services, physical and occupational therapy, early identification and assessment of disabilities, counseling services, school health services, social work services in schools, and medical services for evaluation and diagnostic purposes only.[3]

Although states and localities fund the bulk of special education services, Federal Part B funds are an important supplement. To receive Part B funds, a state must submit a plan through its state education agency (SEA) detailing state policy for ensuring that children with specified disabilities have access to a free appropriate public education. The state application also must include an estimate of the total number of children with disabilities currently receiving and/or in need of special education and related services. The state must also provide estimates of the personnel and other resources necessary to meet the special education needs of children as specified by the Act. The distribution of funds among states is determined by a formula based on the number of children with disabilities age 3 through 21 receiving special education and related services within each state.

Once Part B monies have been approved, they are forwarded to the SEA for distribution to local education agencies (LEAs). LEAs generally are comprised of one or more local school districts. The LEAs receive funds only after they have submitted a program plan and been granted approval by the SEA. The LEAs are then expected to provide services to students with specified disabilities. State and local education agencies are prohibited from reducing their existing financial commitments to special education in response to the receipt of Part B funds.

For students with specified disabilities eligible for special education services under Part B, an Individualized Education Program (IEP) must be developed cooperatively by the school, the child's teacher, the child's parent or guardian, and others if deemed appropriate. Developed by the beginning of the school year, and reviewed (and if appropriate revised) at least annually, the IEP must detail specific special education and related services that are to be provided to the child. The LEA is responsible for assuring that all services included in the IEP are provided to

[3] In certain instances, some of the services in this list could be furnished for educational or vocational purposes rather than for health purposes. Such services would not be reimbursable by Medicaid. The remainder of this booklet addresses health-related services provided for medical or remedial purposes.

the child and that education occurs in the "least restrictive environment," meaning that the child is educated with non-disabled peers to the maximum extent appropriate.

B. THE MEDICAID PROGRAM

Medicaid is a nationwide Federal/state medical assistance program for selected low-income populations. The Medicaid program was established in 1965 as Title XIX of the Social Security Act. It is federally administered by the Health Care Financing Administration (HCFA) within the U.S. Department of Health and Human Services (DHHS). While Congress and HCFA set broad Federal guidelines for the program, states have considerable flexibility in formulating eligibility, benefits, and reimbursement policies. Every state documents these policies in a state Medicaid plan which must be approved by HCFA.

The Medicaid program is funded by a combination of Federal and state dollars. The Federal Government "matches" state dollars as long as both the services and the eligible populations are within the parameters approved in the state plan. The level of the Federal match, known as Federal Financial Participation (FFP), is determined by a formula based on state per capita income. The minimum FFP in state expenditures for medical services is 50 percent of total program costs; the maximum FFP is 83 percent.

Medicaid is a "categorical," means-tested program. Individuals must fit into specific categories (e.g., dependent children) and must have income and resources below specified thresholds. Until recently, Medicaid eligibility was linked almost exclusively to eligibility for Federally funded cash assistance under two programs: Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI). AFDC and SSI are "categorical" programs. AFDC recipients live in families with a single or unemployed parent and SSI recipients are aged, blind, or disabled. States are also able to establish "Medically Needy" programs to cover individuals who meet the categorical eligibility criteria for cash assistance but not the income and resource eligibility criteria. Under a Medically Needy program, states may extend eligibility to individuals with family incomes up to 133 percent of the state's AFDC payment standard and also to individuals who incur health expenses which, when deducted from income, bring their net income below the medically needy level.

Recent Federal legislation has diminished the link between eligibility for cash assistance and Medicaid. Medicaid has been expanded to include many young children with family incomes and resources well above state eligibility standards for cash assistance. Moreover, many of these children qualify for Medicaid regardless of whether they have disabilities or are in single-parent families.

Medicaid covers a broad range of medical and remedial services. Federally allowable services include not only traditional medical services and remedial care, such as physicians' services and prescription drugs, but also several health and therapeutic interventions, such as occupational therapy. Some services are mandated by Federal law and must be provided by every state, while other services are provided at a state's discretion. One special program established for children is the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Under the EPSDT program, children must receive not only screening and diagnostic services, but also any medically necessary treatments that may not otherwise be available under a state's Medicaid plan but are allowable under Federal Medicaid law.

Medicaid services may be provided by a range of health professionals in a variety of settings, including a child's home or school. However, in defining service benefits, states have some latitude in specifying the types of providers and settings in which services must be provided in order to be reimbursable.

In general, state Medicaid programs pay participating providers for covered services on a per unit of service basis (such as a physician office visit). Within Federal guidelines, states have flexibility in determining reimbursement rates for particular services and providers. Providers generally bill Medicaid directly for payment for covered services provided to Medicaid recipients. States have the option of requiring nominal cost-sharing by Medicaid recipients for some services, meaning that the recipient pays a small "copayment" (e.g., $2.00) to the provider for a given service.

In sum, states have considerable flexibility in defining Medicaid eligibility groups, benefits, provider participation requirements, and reimbursement levels within Federal guidelines. It is because of this flexibility that states can shape their programs to include reimbursement for health-related services required under the Part B program, a process that can be facilitated through interagency agreements between the state's Medicaid agency and education agencies.

C. QUESTIONS ADDRESSED BY THE HANDBOOK

Federal policy has established that education agencies can bill Medicaid for health-related services covered under the state's Medicaid program. However, there has been considerable confusion about Federal policy, and the various laws and regulations governing the billing and reimbursement process can be complicated and ambiguous. This booklet seeks to clarify the relevant Federal policies in response to the questions shown in Exhibit 1.

QUESTIONS AND ANSWERS

A. IDEA POLICY REGARDING MEDICAID BILLING

1. Does Federal Part B policy allow Medicaid billing for health-related services covered under a state's Medicaid program?

Yes. Although Part B does not expressly require Medicaid billing for covered health-related services, Congress anticipated the use of Medicaid and other resources to finance health-related Part B services. The Senate Report accompanying the original act, P.L. 94-142, states that "the state education agency is responsible for assuring that funds for the education of handicapped children under other Federal laws will be utilized" and that "there are local and state funds and other Federal funds available to assist in this process."

Moreover, three statutory amendments to Part B, made in 1986 by P.L. 99-457, further support the use of Medicaid and other sources to finance IEP-related services. Under these amendments:

- States are prohibited from using Part B funds to satisfy a financial commitment for services that would have been paid for by other Federal, state, and local agencies but for the enactment of Part B and the listing of the services in an IEP;
- States are required to establish interagency agreements with appropriate state agencies to define the responsibility of each for providing or paying for a free appropriate public education and resolving disputes; and
- It is clarified that P.L. 94-142 cannot be construed as permitting a state to reduce medical or other available assistance, or to alter Title V Maternal and Child Health Block Grant or Medicaid eligibility with respect to the provision of a free appropriate public education.

2. Are there any Federal special education policies that limit the circumstances under which the Medicaid program can be billed for health-related services?

The only Federal education policy that could restrict Medicaid payment for covered health services is the basic IDEA requirement that special education services be provided "at no cost to parents." The effect of this provision is that state or local education agencies must assume any costs the Medicaid agency does not pay for so that no costs are imposed on the parents. For example, if the state Medicaid agency has elected to exercise its Federal option to impose nominal cost-sharing requirements on Medicaid recipients for services that include health-related services furnished by schools, the state or local education agency would be required to meet these copayment obligations for an eligible family.[4]

[4] In addition, Medicaid does not pay medical expenses that a third party, such as a private health insurance company, is legally obligated to pay. While Medicaid can be billed for covered health-related services provided to an eligible Medicaid recipient, to the extent that Medicaid copayment or third-party liability rules apply, the state or local education agency (or the third party) would have to bear those costs. Third party liability is discussed in greater detail in Section F.

B. MEDICAID POLICY REGARDING PAYMENT FOR HEALTH-RELATED SERVICES

1. What are the Federal Medicaid program requirements regarding reimbursement for health-related services?

The Federal Medicaid statute does not require that Medicaid programs reimburse schools for health-related services delivered to Medicaid-eligible children. However, the Medicare Catastrophic Coverage Act of 1988 (MCCA) amended the law to make clear that Medicaid funds are available to pay for health-related services.[5] The amendment states that nothing under the Medicaid statute is to be construed as prohibiting or restricting, or authorizing HCFA to prohibit or restrict, payment for services covered under a Medicaid state plan simply because they are furnished to a handicapped child pursuant to an individualized education program (IEP). The implication, as explained in the Conference Report, is that state education agencies are responsible for furnishing special instruction and educational services to children with disabilities, but that state Medicaid agencies are responsible for reimbursing health-related services provided to Medicaid-eligible children to the extent the state covers them under its Medicaid plan.

2. Are there any Federal Medicaid policies that limit the circumstances under which the Medicaid program can be billed for health-related services?

Under Federal law, the Medicaid program can only be billed for medically necessary services that are included in the state's Medicaid plan and provided by participating Medicaid providers. An exception to this is services provided under the EPSDT program (see Section C). In addition, except under circumstances described in Section F, Medicaid does not pay medical expenses that a third party, such as a private insurance company, is legally obligated to pay.

3. What state Medicaid policies must be in place in order for schools to bill Medicaid for medically necessary health-related services?

In order for schools to be able to bill Medicaid, the state Medicaid program must cover the various health-related services a child may need (e.g., physical therapy) under one of the service categories in its Medicaid state plan. In addition, the state Medicaid agency needs to have qualifications for providers of health-related services that schools or their practitioners would be able to meet (see Section E for a discussion of provider qualifications). These policies need to be reflected in the state Medicaid plan (see section G). However, while the state Medicaid agency can establish qualifications which would allow schools or their practitioners to be providers, it may not specify schools or their practitioners as the sole providers of health-related services.

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[5] Shortly before the Medicaid statute was amended, the First Circuit Court of Appeals in the case of Massachusetts vs. Secretary of HHS, 816 F.2d 796 (1st Cir. 1987) upheld a Federal District Court decision prohibiting the denial of Federal Medicaid funds for an otherwise covered service solely on the basis that the service was provided pursuant to the state special education law and included in a child's IEP. The Court had held that the Massachusetts Department of Education was not liable as a first-party payer under Medicaid law. It also had held that the inclusion of a service in an IEP did not automatically establish the service as educational, rather than medical, in nature. The Supreme Court affirmed the jurisdiction of the Federal District Court to make such a determination in Bowen vs. Massachusetts, 487 U.S. 879 (1988).

4. ***If a Medicaid recipient also has private insurance, must the private plan be billed for health-related services?***

Yes. Medicaid does not pay medical expenses that a third party, such as a private insurance company, is legally obligated to pay. When individuals apply for Medicaid, they are required to inform the state Medicaid agency of any other health care coverage they have and permit the state Medicaid agency to pursue payment from these third-parties for covered services.

Medicaid providers, including schools and their health care practitioners, must bill private plans first if a Medicaid recipient has private coverage for the relevant service.[6] As a result, Medicaid reimbursement would not be available, or would be available only in a substantially reduced amount, for services to Medicaid-enrolled children who also have private health insurance coverage for health-related services.

Whether a school actually would choose to bill private insurers for services covered by more than one source of insurance would depend on the school's policies regarding health insurance billing and the potential for an associated cost to the family. Under Federal policy on use of parents' insurance proceeds, the requirements that a free appropriate public education be provided "without charge" or "without cost" mean that an agency may not compel parents to file an insurance claim when filing the claim would pose a realistic threat that the parents of children with disabilities would suffer a financial loss not incurred by similarly situated parents of other children. Financial losses include, but are not limited to, the following:

- A decrease in available lifetime coverage or any other benefit under an insurance policy;
- An increase in premiums under an insurance policy; or
- An out-of-pocket expense such as the payment of a deductible amount incurred in filing a claim.[7]

If such a cost would be incured, a parent's use of insurance proceeds would have to be voluntary. If a school determined that private insurers could not be billed for dually insured services, then Medicaid could not be billed for these services either, and the state or local education agency would have to bear the costs which Medicaid and the third parties would have been obligated to pay.

5. ***If providers bill a state Medicaid program for services to Medicaid recipients, must they also bill non-Medicaid children's parents or third-party payers for health-related services?***

No. This question often arises because of the Federal requirement that Medicaid payments are not available for services that are otherwise provided free of charge. Federal Medicaid policy is that all health-related services provided under Part B that are covered by a state's Medicaid program may be billed to Medicaid regardless of whether parents and third-party payers for non-Medicaid eligible children also are billed. (See Questions A.1 and B.1 above)

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[6] There are some exceptions to the usual requirement that state Medicaid agencies refuse to make payment until other liable third parties are billed. Final regulations published January 16, 1990 require states to pay claims first and then seek reimbursement from other liable third parties for several specific services, including preventive pediatric services such as EPSDT and services provided to a child where an absent parent is under court order to provide medical support.

[7] 45 Federal Register 86390 (December 30, 1980).

C. MEDICAID COVERAGE OF HEALTH-RELATED SERVICES

1. Which health-related services are Federally allowable Medicaid services?

The Medicaid statute establishes a broad scope of services including health-related services that may be furnished as part of a special education program and reimbursed. Part B services are potentially reimbursable if the State chooses to include them in its Medicaid plan.[8] These include: speech pathology services; occupational therapy; physical therapy; psychological services; school health social worker services; early identification, screening, and assessment services; and medical services for diagnostic or evaluative purposes.

The Federal Government requires that states cover certain Medicaid service categories and allows states the option of covering others.[9] The mandatory categories (i.e., those that are Federally required) include physician services, outpatient hospital services, and EPSDT. The optional categories include: physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders; medical and other remedial care provided by licensed practitioners (such as psychologists, social workers, and nurses); clinic services; diagnostic, screening, and rehabilitative services; nursing facility services (including services in institutions for the mentally retarded); and inpatient psychiatric services for individuals under age 21. Among these various Medicaid benefits, the rehabilitative services category — which carries no Federal requirements for physician prescription, provider qualifications, or setting limitations — is the most flexible.

Many Part B health-related services can be reimbursed under more than one Medicaid service category. The ancillary therapies, for example, can be reimbursed as therapies furnished by independent practitioners or as components of clinic or rehabilitative services.

While all medically necessary health-related services are potentially reimbursable, payment can only occur if the state Medicaid plan clearly covers the service. Thus, it is important that education agencies work closely with the state Medicaid agency to ensure that the scope of the appropriate benefit category is defined by the Medicaid plan so as to include health-related services that might be furnished in a school and to ensure that the provider qualifications in the plan are defined in a way which would permit schools to participate.

2. What is meant by the Federal Medicaid requirement that a service be medically necessary?

Medical necessity is a prerequisite for service payment under the Medicaid program. This stems from various provisions in the Medicaid statute that require states to safeguard against unnecessary utilization of care and services.

Federal law leaves the specification of medical necessity criteria for particular Medicaid services to the discretion of the state. There are a few services, though, including the ancillary therapies, for which physician referrals or prescriptions are Federally required as evidence of medical necessity. For instance, prescriptions are required for both physical and occupational therapy services and a referral is necessary for speech pathology and audiology services. States

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[8] The reader should note that these reimbursable services do not include educational and vocational services.

[9] The Federal requirement applies only to services provided to categorically eligible recipients (i.e., those receiving cash assistance and pregnant women and young children). States are permitted to provide more limited coverage of ambulatory services to medically needy recipients.

then are free to establish more specific medical necessity criteria as they wish, and to limit the coverage for services based on these criteria as well as on utilization control procedures. (State Medicaid coverage limits, of course, do not relieve a state of its responsibility for providing services to children under an IEP.)

3. *What is the Medicaid EPSDT program for children?*

Early and periodic screening, diagnosis, and treatment services — EPSDT — is a Federally required benefit for Medicaid-eligible children from birth to age 21. The EPSDT benefit is substantially different from other Medicaid benefits in that it obligates states to provide for all necessary Federally allowable Medicaid services regardless of the limitations in a particular state's Medicaid plan. To be in compliance with the Federal mandate for furnishing EPSDT, states are required to inform families of Medicaid-enrolled children about the benefits of preventive health care and the availability of EPSDT services, to assist with referrals and transportation to providers, and to arrange for provision of necessary diagnostic and treatment services, either directly or through referral.

EPSDT screening services include a comprehensive health and developmental screen (which includes a mental health assessment), a dental examination, a hearing examination, and a vision examination. These services are to be available in accordance with a state's periodicity schedule (or timetable), which must be established for each of the four components of the screening package and must meet reasonable standards of practice. These services are covered at other times as well, provided that the particular screening service is determined to be medically necessary.

Services for diagnosis and treatment include all Federally allowable Medicaid services. Diagnostic services are covered whenever a screening examination indicates the need to conduct a more in-depth evaluation of the child's health status and to provide diagnostic studies. Treatment services are covered whenever they are medically necessary to correct or ameliorate defects, physical or mental illnesses, or other conditions discovered (or found to have worsened) through an EPSDT screening. Both types of services are to be covered whether or not they are included in the state Medicaid plan and available to other Medicaid recipients.

4. *What is the significance of the new Federal EPSDT mandate to furnish all medically necessary diagnostic and treatment services?*

Federal law now requires states to provide reimbursement for any Federally allowable service found to be necessary to treat a condition discovered during an EPSDT screen, regardless of whether the service is included in the state Medicaid plan. Prior to this change, state Medicaid programs had the option to provide EPSDT-screened children an expanded package of Medicaid benefits but were not required to do so.

The new EPSDT mandate means that a broader scope of services and more generous coverage may be available to many Medicaid children. State Medicaid programs must now reimburse for diagnostic and medically necessary treatment services that otherwise are considered optional under Medicaid law. They also are prohibited from imposing limits on services that are not based on medical necessity requirements.

Recent HCFA preliminary instructions on EPSDT make clear, however, that states retain at least some of their usual limit-setting authority. Importantly, they remain responsible for setting medical necessity criteria for all EPSDT services. Using these criteria they also can limit both the scope of services — the nature of the intervention and the types of delivery settings for

which reimbursement will be available — and the amount of service covered. Yet, any limitation imposed must be reasonable and related to medical necessity, and the benefit provided must be sufficient to achieve its purpose for EPSDT children.

5. Are health-related services included under the new EPSDT mandate?

Yes. Federally allowable Medicaid services mandated under EPSDT when medically necessary include, for example: clinic services; rehabilitative services; physical therapist services; occupational therapist services; speech pathology and audiology services; licensed psychologist and social worker services; and inpatient psychiatric facility services for individuals under age 21. Again, if a child is determined to need these services through an EPSDT screen, the services must be provided whether or not they are otherwise included in the state plan.

6. What is necessary for schools to bill for expanded EPSDT services?

To bill for medically necessary EPSDT diagnostic and treatment services not otherwise covered under a state's Medicaid plan, a school must take steps to assure that:

- It or its health care practitioners, depending on the Medicaid service, is certified by the state as a Medicaid EPSDT provider;
- It can document the ongoing medical necessity of the health-related services it furnishes for conditions discovered or found to have worsened on the basis of a screening examination; and
- If required to do so by the state, it has obtained prior authorization for payment on a case-by-case basis.

D. MEDICAID ELIGIBILITY AND ENROLLMENT

1. Which children are eligible for Medicaid?

Medicaid coverage is currently required for all children under the age of six with family incomes below 133 percent of the Federal poverty level. States also must cover most children eligible for the two major Federally subsidized cash assistance programs: Supplemental Security Income (SSI), a program for the aged, blind, and disabled; and Aid to Families with Dependent Children (AFDC). Both programs are means-tested. The income eligibility standards for AFDC, which are established by the states, are generally much lower than the Federal poverty level. By the year 2002, states will be required to cover all school-age children (up to age 19) in families with incomes below 100 percent of poverty. Coverage of this group of children is being phased in one year at a time beginning with ages six and seven in July 1991.

State Medicaid programs have the option of covering some additional school-aged children who cannot qualify for either SSI or AFDC. Financially eligible children in two-parent families, for example, may be unable to obtain AFDC but may nonetheless qualify for Medicaid in many states. Likewise, children with family incomes somewhat higher than the AFDC or SSI eligibility standards may qualify for Medicaid under the optional "Medically Needy" program. Adopting this program option allows states to set an income standard up to one-third higher than

for the AFDC program and allows families to qualify for Medicaid when their income is below this medically needy standard or when they meet the medically needy standard by deducting incurred medical expenses from income.[10]

2. ***How do eligible children become enrolled in Medicaid?***

Medicaid-eligible children cannot receive Medicaid benefits until they are formally enrolled in the program.[11] While most children receiving AFDC and SSI are automatically enrolled in Medicaid when their application for those programs is completed, children not receiving cash assistance must apply specifically for Medicaid coverage. Families, though, cannot be forced either to apply for or accept Medicaid benefits.

Families who want to have Medicaid coverage are Federally required to meet several specific eligibility criteria which must be documented and verified by the state through the enrollment process. States establish their own eligibility determination and enrollment procedures. In general, the process includes completing an application with information on family income and assets, other health insurance coverage, family size and composition, and other factors. The application process is usually conducted at local welfare or social service offices, although states are required (beginning July 1, 1991) to deploy outreach eligibility workers at other sites, such as hospitals or clinics. Once an application is submitted, the state has 45 days from the date of application to complete the eligibility determination (90 days for persons claiming disability as a reason for eligibility). When eligibility has been established, individuals must identify any other health care coverage they have and permit the state Medicaid agency to pursue payment from this third party coverage if it is legally obligated to pay for covered services. The family then is issued documentation (often a card) identifying their enrollment in Medicaid.

Importantly, establishment of eligibility is not permanent. Federal regulations require that states must conduct Medicaid eligibility redeterminations at least every 12 months. Redeterminations for AFDC recipients are conducted every six months. Redetermination generally entails verification of eligibility criteria — such as income, family composition, and age of children — and does not require reapplication.

3. ***Is it a violation of Medicaid confidentiality requirements for local education agencies to require parents to provide information on the Medicaid enrollment status of children receiving health-related services?***

No. Federal Medicaid regulations do not preclude providers or others from requiring parents to provide information on whether their children are enrolled in Medicaid. Under Part B, however, state and local education agencies are prohibited from requiring parents to identify whether their children are enrolled in Medicaid as a condition for receiving health-related services. Education agencies may request this information from parents, but parents are under no obligation to provide it.

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[10] There are several other categories of eligible children, some of which include a large proportion of children in need of special education. These are primarily adopted children, and children in foster care covered under provisions of Title IV-E of the Social Security Act, and (at the state's option), children with disabilities living at home who otherwise would be eligible for Medicaid only if they were institutionalized.

[11] HCFA uses the term "eligible" to denote individuals who are enrolled in Medicaid. For purposes of clarity, we define eligible individuals as persons who meet Medicaid eligibility criteria regardless of whether they have applied for the program, and we use the term "enrolled" to denote those persons who have completed the application process and have been issued a Medicaid card.

4. Can Medicaid enrollment information be furnished to education agencies by the state Medicaid program?

If the local education agency is a certified provider under the state's Medicaid plan, it may obtain information from the state Medicaid agency to verify the enrollment status of a particular child. It may not, however, request a comprehensive list of Medicaid-enrolled children. While Federal regulations require that the state Medicaid agency obtain permission from a family or individual for the release of any personal Medicaid-related information to an outside source, the Medicaid agency is permitted to release information without that consent if the information is necessary to verify enrollment.

E. PROVIDER PARTICIPATION IN THE MEDICAID PROGRAM

1. What Federal requirements must be met to become a provider of Medicaid services?

Federal law is specific about standards and certification procedures for hospitals and other inpatient care providers, but it leaves states considerable discretion in establishing Medicaid qualifications for individual practitioners and most other types of community-based providers. HCFA requires only that state provider standards be reasonable and objective with respect to the services covered. Because Federal law requires that Medicaid recipients have "freedom-of-choice" among providers — that is, the opportunity to choose among all health care providers who are qualified to participate — state Medicaid programs are expected to permit all qualified providers of Medicaid services to participate in the program.[12] The state Medicaid agency cannot specify a particular provider, such as schools, as the sole provider of Medicaid services.

All Medicaid providers, including schools or their practitioners, must abide by the Federal payment-of-claims provisions where third parties are involved. This means that, as a Medicaid provider, a school or its medical practitioner may be required to bill a private health insurance company first before billing Medicaid, unless the specific service meets one of the regulatory exceptions or the state has obtained a waiver of the cost avoidance requirements. If by billing the private insurer the school or its medical practitioner would be in violation of the IDEA requirement that services be provided at no cost to the parents, then the state or local education agencies must assume full financial responsibility for those services for which Medicaid would otherwise pay.

2. Is state licensure ever Federally required for providers of particular Medicaid services?

Yes. Licensure is a Federal condition of participation for the services of physicians, dentists, and certain other practitioners such as psychologists, social workers, and nurses. Where they exist, state licensure requirements also apply to physical therapists. Otherwise, ancillary therapists are only Federally required to meet standards concerning education and professional certification.

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[12] If a family chooses to receive health-related services from providers that are not affiliated with a school, they would be expected to pay any applicable copayments specified by the state Medicaid agency.

3. May schools qualify as Medicaid providers and bill for health-related services?

Yes. Schools may be certified as Medicaid providers if they meet the state's provider qualifications (see Questions E.1 and E.2 above) for the appropriate covered service. Depending on the state, schools may qualify as rehabilitative service providers. They may also qualify, on the basis of their salaried and consultant practitioner staff, as providers of ancillary therapist, psychologist, social worker, and certain other practitioner services. Billing by schools or other facilities for the services of individual practitioners is permitted as long as it is a condition of employment or a service contract.

Federal Medicaid law otherwise requires that only providers who directly furnish Medicaid services may bill the Medicaid program. On a voluntary basis, direct providers may allow schools to bill for them. Medicaid providers, including schools, may elect to use a third party as a billing agent to prepare and submit Medicaid claims. Billing agents may charge providers a reasonable fee for their services if the amount is unrelated to the amount of Medicaid revenues collected, but they may not advance providers funds prior to the payment of Medicaid claims.

4. What are examples of provider qualifications that have been Federally approved for health-related services?

It is common and acceptable practice for states to establish Medicaid provider qualifications that reference the standards of applicable licensing agencies or boards. For certain types of services, though, particularly those not traditionally recognized by state licensure laws, Medicaid agencies generally develop their own provider standards and certification procedures. In many states, Medicaid plan amendments specifying provider qualifications for health-related services already have been approved by HCFA. These qualifications have addressed criteria such as education, training, experience and, depending on the service, supervisory capacity and participation in referral agreements.

5. What is the financial liability of Medicaid providers in cases where reimbursement is subsequently disallowed by HCFA?

HCFA's relationship is with the state Medicaid agency. In cases where HCFA disallows Federal funds for an already reimbursed service, it is the state Medicaid agency's decision whether to require that some or all of the Medicaid payment be returned by the provider.

F. MEDICAID REIMBURSEMENT RATES AND CLAIMS SUBMISSION

1. What are the Federal requirements governing Medicaid payments to providers?

Under Medicaid law, states have considerable freedom in developing their own methods and standards for Medicaid reimbursement rates. Only three general Federal requirements apply to all types of services. First, "methods and procedures" for making payments must be such as to assure that payments will be "consistent with efficiency, economy, and quality of care." Second, payment rates must be sufficient to attract enough providers so that covered services will be as available to Medicaid recipients to the same extent as to the general population in the geographic area. Third, Medicaid providers must accept the amount reimbursed by Medicaid as payment in full.

A few other Federal rules apply to specific types of providers, but they are less likely to be relevant to health-related services. For example, payment for services furnished by organized health providers (such as clinics) must not exceed the amount that would have been paid for comparable services in comparable settings if provided to a Medicare beneficiary. Most Part B health-related services, however, are rarely comparable to services provided to a Medicare beneficiary.[13] Also, payment for ambulatory services provided by Federally qualified health centers (including community health centers and migrant health centers) must equal 100 percent of reasonable costs. This provision would be relevant in situations where a Federally qualified health center is rendering Part B services for the local education agency.

Importantly, states are permitted to establish separate classes of providers and pay them differentially. Publicly operated health care facilities and state-employed individual practitioners, for example, could be a class of providers paid by Medicaid at or near their full costs (provided that costs do not violate the guidelines and rules described above).[14] Facilities and practitioners that receive state funds (other than Medicaid) could be another class of providers. At the same time, other private agencies and practitioners could be a class of providers reimbursed through existing methodologies in the state, such as a percentage of their usual and customary charges.

2. *What methods can states use to determine Medicaid payment rates for covered services?*

With the exception of the requirements described above, there are no specific rules governing how states should develop Medicaid payment rates. State Medicaid agencies thus have established a variety of methodologies for determining reimbursement rates. The methodologies are detailed in their state Medicaid plans and generally vary by type of provider. For individual practitioners, Medicaid payment is usually the provider's actual charge for the service or a maximum payment amount established by the state, whichever is lower. Fixed fee schedules are the most common method for determining maximum payment amounts, although states may use other methods. For organized health providers, such as clinics, state Medicaid agencies generally determine payment rates using either cost-based reimbursement principles or fee schedules. Thus, it is possible in many states for particular classes of organized providers to have their full costs covered by the Medicaid payment, provided that the Federal guidelines described above are met.

3. *How are Medicaid-covered services billed?*

There are no specific Federal requirements establishing standard billing procedures for Medicaid services. Providers may send claims directly to the state Medicaid agency or its designated fiscal agency (i.e., an organization under contract with the Medicaid agency to complete claims processing) for reimbursement. Claims generally must be submitted on a state standard form and must include pertinent information, such as a valid recipient number and a complete description of the services provided, in order to be processed in a timely manner.

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[13] For example, occupational therapy may be provided to overcome sensory integration or motor planning deficits among children, but may be used to address problems associated with physical inactivity and inability to perform self-care among the elderly.

[14] Cost principles for state and local government entities are set forth in the U.S. Office of Management and Budget (OMB) Circular A-87.

4. Who can bill for reimbursable services?

Any provider who is qualified under a state's Medicaid rules (see Section E) may bill Medicaid for medically necessary covered services provided to Medicaid recipients. Qualified Medicaid providers are usually issued a provider number that identifies them as such and must be included when filing claims.

As discussed earlier, Medicaid providers (including schools) may elect to use a third party as a billing agent to prepare and submit Medicaid claims. Billing agents may charge providers a reasonable fee for their services if the amount is unrelated to the amount of Medicaid revenues collected, but they may not advance providers funds prior to the payment of Medicaid claims.

5. What kinds of records must be maintained by Medicaid providers?

Federal regulations require providers to keep any records necessary to establish the extent of services they provide to individual Medicaid recipients and information regarding payment for services requested by the state Medicaid agency. State Medicaid agencies generally specify a record and billing format that is compatible with their information and payments data systems. In addition, they often require providers to submit uniform cost reports as well as financial and statistical data.

6. Must providers show evidence of billing other liable third parties prior to billing Medicaid?

If a provider is aware of another liable third party, then the provider must bill that third party and show evidence of billing (such as the denial of the claim) to the state Medicaid agency before Medicaid will remit payment. This practice, known as cost-avoidance, is required except if the specific service for which reimbursement is sought meets one of the regulatory exceptions or if the State has obtained a waiver of the cost avoidance requirements. Under these circumstances, the state Medicaid agency is permitted to pay for the service and subsequently seek to recover costs from liable third parties.

Federal regulations allow providers to obtain information on a Medicaid recipient's other insurance through access to the recipient's case file. However, if a provider is unaware of other third-party liability, or has no reason to believe that the services provided will be covered under the recipient's other insurance (as is likely to be the case with several health-related services for children), the provider may proceed to bill Medicaid.

G. MEDICAID STATE PLANS

1. What are the Federal requirements for state Medicaid plans?

To receive Federal matching funds, each state must have an approved state Medicaid plan that includes, among other items, descriptions of eligibility, benefits, reimbursement, and administrative policies. States provide the required information by filling out the HCFA-prepared "state plan pre-print" and furnishing necessary attachments.

Annual state Medicaid plan submissions are not required by HCFA, although state laws frequently dictate that Medicaid plans be prepared and reviewed each year. Similarly, public notice is not Federally required for state plan amendments (except for significant payment methodology changes), but is often mandated by states.

2. How are state Medicaid plans revised?

State Medicaid plans may be revised at any time. Amendment requests are sent to the appropriate HCFA regional office, which has 90 days within which to approve the amendment, reject it, or request additional information. Regional offices have authority to approve or request additional information on plan amendments but do not have the authority to reject a state plan amendment. Only the HCFA Administrator can disapprove an amendment following consultation with the Secretary of DHHS. Moreover, if at the end of the 90-day period HCFA has not responded to the request, the amendment is deemed to be approved. If additional information is requested on a plan amendment, HCFA has a new 90-day period to approve or disapprove the amendments once the additional information is received.

3. Who can submit Medicaid plan amendments?

Only the single state agency responsible for administration of the Medicaid plan can submit Medicaid plan amendments.

H. CERTIFICATION OF THE STATE'S SHARE OF MEDICAID PROGRAM COSTS

1. What kinds of funds may be used to provide a state's share of Medicaid program costs?

Federal law provides that both public and private donated funds may be considered as the state's share of Medicaid program costs. There are certain conditions, though, that apply to each source of funds.

Public funds used to claim Federal Financial Participation (FFP) must be funds that are appropriated directly to the state or local Medicaid agency, are transferred to the Medicaid agency from another public agency, or are certified by a contributing public agency as eligible state-match expenditures under the Medicaid program. Public funds may not be Federal funds, such as IDEA funds, that are otherwise provided for the state's use. Nor may they be state funds already obligated as state matching funds for another Federal program.[15]

Privately donated funds used to claim FFP must be funds that are transferred to the state or local Medicaid agency and are under its administrative control. Such funds may revert to a donor's facility only at the discretion of the Medicaid agency and only if the donor is a non-profit organization.[16]

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[15] Public funds may be derived from both general tax revenue and provider-specific tax revenues. However, as specified in an interim final rule (implementing statutory provisions) issued on September 12, 1991 and clarified on October 31, 1991, FFP is not available for that portion of states' payment to facilities for costs attributable to a provider-specific tax. The issue of using provider-specific taxes as the state share of Medicaid program costs has been the subject of controversy.

[16] The issue of using voluntary private contributions to finance a state's share of Medicaid program costs has also been controversial. HCFA's September 12, 1991 interim final rule and the October 31, 1991 clarification require that donations from providers be offset from Medicaid expenditures before calculating the Federal share. Currently, however, there is a Congressionally mandated moratorium on issuing final regulations until January 1, 1992.

2. ***What is required for state and local education agencies to certify their contribution?***

There are no Federal requirements regarding certification of the state Medicaid match by schools and other contributing public agencies. Federal policies concerning the receipt of FFP pertain only to state Medicaid agencies, which are required to document allowable Medicaid expenditures for broad service categories in the HCFA-prepared "state Medicaid expenditure report" form. States are expected to generate the requisite data for this report on the basis of their own expenditure reporting systems.

☆ U. S. Government Printing Office: 1991 - 617-871 (41102)